

**NEW YORK STATE DEPARTMENT OF HEALTH**  
Bureau of Emergency Medical Services

**EMT- INTERMEDIATE  
RECERTIFICATION FORM**  
Continuing Education Recertification Program

**Print Neatly in UPPER CASE Letters - Please Complete ALL Information – Incomplete forms will be denied and returned**

EMT Number







Social Security Number











Last Name




















First Name




















MI

Address





















City

















State



Zip Code











Enter Agency Code of Your Participating Agency







I affirm that in accordance with the requirements of 10NYCRR Part 800.8(e), I have not been convicted of or am not currently charged with any misdemeanors or felonies. I understand that if I have a conviction it will be individually reviewed and that any such conviction may not be an automatic bar to certification. The Department of Health will determine if the conviction is applicable under the provisions of 10NYCRR Part 800.

Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_

**EMT-B Refresher Training - 24 Hours**

DIVISION	Required Hours	Hours Earned	CIC Signature	CIC Number
Preparatory	1			
Airway	2			
Patient Assessment	3			
Medical/Behavioral (see sub categories)				
Gen. Pharmacology/Respiratory/Cardiac	4			
Diabetes/Altered Mental/Allergies	2			
Poisoning/Environmental/Behavioral	2			
Trauma	4			
Obstetrics/Gynecology	2			
Infants and Children	2			
Elective	2			
<b>TOTALS</b>	<b>24</b>			

**CPR Certification**

As the participant's CPR Instructor I hereby verify that the participant has satisfactorily completed and shows competence in:  
Adult, Child and Infant 1 & 2 rescuer CPR an Obstructed Airway management

Printed Name of Instructor \_\_\_\_\_

Signature of Instructor \_\_\_\_\_

Date \_\_\_\_\_

**\* A COPY OF THE CARD ISSUED MUST ACCOMPANY THIS APPLICATION IF THE INSTRUCTOR DOES NOT SIGN \***

**EMT-I Refresher Training - 10 Hours Total in These Topic Areas**

Topic	Required Hours	Hours Earned	Date
Preparatory	2		
Advanced Airway Management / Ventilation	3		
Patient Assessment	2		
Trauma	3		
<b>TOTALS</b>	<b>10</b>		

**Additional 38 Hours of Continuing Education – Must include mandatory training in Geriatrics and WMD as noted!**

Topic	Hours	Date	Topic	Hours	Date
Geriatrics – 3 hours minimum					
WMD/Terrorism – 3 hours minimum					
<b>Total Hours</b>					

**Skill Competency Verification**

Skill	QA/QI	Direct Observation
<b>Patient Assessment</b> (Medical and Trauma)		
<b>Airway/Ventilation</b> (Simple Adjuncts, Advanced Adjuncts, Supplemental Oxygen Delivery, Bag Valve-Mask – one and two rescuer)		
<b>Cardiac Arrest Management / AED</b>		
<b>Hemorrhage Control &amp; Splinting</b> (long bone injury, joint injury, and traction splinting)		
<b>IV Therapy</b>		
<b>Spinal Immobilization</b> (Seated and Supine)		

As the Physician Medical Director for the Participant's Continuing Education Program I hereby affix my signature attesting to proficiency in all skills outlined above.

Printed Name of Medical Director \_\_\_\_\_ Signature of Medical Director \_\_\_\_\_ Date \_\_\_\_\_

I hereby affirm that all statements on this recertification form are true and correct, including all copies of cards, certificates and other required verification. It is understood that false statements or documents submitted with the intent to falsely recertify may be grounds for revocation of certification and applicable civil and criminal penalties. It is also understood that the Bureau of Emergency Medical Services or its designee may conduct an audit of the activities listed herein at any time. **This form must be mailed and postmarked no less than 45 days prior to your current expiration date!**

Signature of Participant \_\_\_\_\_

Signature of Sponsoring Agency Contact / Coordinator \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_